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Being a mental health nurse can be a fraught experience, leading the reflective practitioner to question where they sit in relation to fellow nurses, fellow mental health professionals, patients and service users. We may question our position in relation to the broad spectrum of fellow mental health nurse colleagues, who work in a diversity of settings (compare the mental health nurse in a high secure setting with one working in a dementia memory clinic, for example). Whilst some aspects of mental health nursing are tasks, such as completing assessments and administering medication, mental health nurses themselves define the work in terms of forming and maintaining therapeutic relationships, 'therapeutic use of self' (Hurley et al, 2009) and 'being with' people (Hercelinskyj, 2014). Newly qualified nurses speak more about nursing professional 'values' than nursing 'skills' (McCrae et al, 2014). Values are seen as central to the work, coming before and determining action. We are professionally socialised into 'being' a nurse, rather than 'doing' nursing.

Nursing has long been seen as one of those professions which requires 'emotional labour' (Smith, 1992; Hochschild, 1983), where the person has to give more than physical or mental effort to fulfil their role. The nurse must draw on their emotional reserves to display the emotional responses required of the therapeutic relationship. The skilled emotional labourer, the expert nurse, does not just 'surface act' their emotions, they 'deep act' them. They use their own genuine emotions in their work. This giving of the self in mental health nursing is

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perhaps most skillful when the nurse must navigate between care and control, when compassion and empathy are tempered by the coercive elements of psychiatric care, those age-old tensions whose currency is demonstrated in recent debates on the reduction of restrictive interventions in mental health care (Duxbury, 2015). In such circumstances we should ask: where do the nurse's emotional reserves come from? Where do their values originate?

A key finding of my study of nurses with personal experience of mental health problems, published in this issue of the Journal of Psychiatric and Mental Health Nursing (Oates et al, 2017) was the extent to which mental health nurses' experiences outside work informed their nursing practice. These experiences motivated them to practice. They created understanding and empathy for service users and, in certain circumstances, participants said that these experiences gave them credibility. Personal experience of mental illness was sometimes explicitly used to inform practice when mental health nurses talked about their own experiences to managers, colleagues and service users. At other times it was a more subtly used resource, one of a range of experiences from which they drew. This notion of experience informing therapeutic contacts within mental health nursing practice was contextualised within a broader picture of nurses using themselves and their experiences in their work. Personal experience of mental health problems was one aspect of the nurse's life which may be used in the work, just as other aspects of family, home or life history may also be used.

Where the nurses described how their nursing practice was shaped by their personal experience, disclosure of the specifics of their mental health problems was not common. The nurses in my study made conscious decisions about disclosure on a relationship by relationship basis, whether with managers, colleagues or service users. Disclosures happened in certain circumstances with certain people, for specific reasons only. Research on disclosure in mental health nursing has rarely previously encompassed disclosure to

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patients by nurses about their own mental health problems, although Ashmore and Banks (2002) found that mental health nursing students were more likely to self disclose than general nursing students, but that they were less likely to disclose to patients than to colleagues. Self disclosure was often justified as a means of progressing the therapeutic relationship and also because of finding they had a shared experience. Even in early days of their career mental health nurses' emotional labour involves a drawing on personal experience from outside of the clinical setting.

For the participants in my study 'use of self' (including drawing on personal experience of mental illness) was seen as part of the mental health nurse's role. Being and becoming a nurse was part of their identity, and identifying with and connecting with people with mental health problems had motivated them to choose a nursing career. Nurses inevitably bring their life experience and subjectivity into work but not necessarily in an overt, explicit way. Personal experience of mental illness can pervade various aspects of the nurse's work life, because the mental health nurse draws on aspects of his or her life experiences, history and personality in order to do the job of nursing, to be a mental health nurse. There has been a lack of acknowledgment of the influence on nursing practice of life outside of the clinical setting. Where emotional labour is an assumed aspect of the role, and use of self is fundamental to 'being' a nurse we should acknowledge that our emotional reserves are drawn from the full range of our life experiences. This includes but is not exclusive to personal experience of mental illness. Taking such a broad perspective on what makes a mental health nurse could ease the friction and anxiety about where we belong and who we are. We could even own and celebrate our complexity and emotional labours, rather than trying to resolve them.

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